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Commentary

Geriatrics in Practice

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DR. ALEX COMFORT'S article[1] and Dr. Malcolm Watts' editorial[2] in the March issue of THE WESTERN JOURNAL OF MEDICINE were splendid and most timely discussions of geriatric medicine, an area with rapidly increasing problems—medical, social, sociologic and economic. Since 1923 as student, intern and longtime family doctor I perforce learned many things about clinical geriatrics.*

Few doctors choose to become geriatricians, or elect geriatrics as a specialty. Many of us after many years of general or specialty practice, without planning or forethought, become aware that an increasing number of our patients have evolved us into, at least part-time, geriatricians. As your practice, your patients and yourself grow older, geriatrics daily becomes more manifest. Usually age and experience enable a doctor to become fairly competent in this field in which the rewards are often more spiritual and intellectual than monetary. The trust and respect, the loyalty and affection, the goodwill and friendship of your older patients can go far to make your own Indian summer richer and more prideful. To our younger colleagues in many disciplines the following thoughts and suggestions are offered in the hope that some may find them of value as their patients, their practices, and their own corporeal changes march into the coming decades.

Those who survive the medical and surgical conditions of infancy and childhood, and as adults in an age of increasing stress eventually emerge into the "senior citizen" class surprisingly do not *usually* raise the challenging problems of diagnosis and treatment which occur in the younger ages. Another way of putting this is that if one can survive the first 50 years and more, diagnostic problems of the 60's, 70's and 80's—again *usually*—are not so difficult. Certainly each one of these several groups have their problems which inexorably worsen with the years—arthritic, diabetic, peptic or colonic, oncologic, hypertensive, psychosomatic and borderline psychiatric (for want of a better term) problems, and the various sclerosis and other "-osis" genera of which we are more and more aware. And, too, they have acute medical and surgical problems superimposed on their major malady. However, the vast majority usually "just go cookin' along" for many years, albeit the path be ever downward. And it is here that our efforts and advice may make those paths easier and kinder.

Our problems in geriatrics are more often in the realm of treatment and management. Somewhere between the frigid determination to "never go to a doctor" and "always running to the doctor" there is a role in which doctors can and should function. Services rendered will be worthwhile and valued by both patients and families. It is particularly regarding the doctor-patient-family relationship that I wish to offer some ideas and suggestions.

Above all if a physician has, regrettably, no empathy for geriatric patients, this should be admitted and a technique developed for graciously referring aged patients to doctors who will and do treat them. Many younger physicians, especially internists and family practitioners recently trained in the new holistic orientation, welcome such referrals and both a patient and the family appreciate the thought and effort in your having made the referral.

Geriatric patients often need, take and demand more time than younger persons; their complaints are more numerous or vague, their loquacity greater and more determined, their comprehension often slowed, and their resistance to change in orders or management frequently more determined. To get through an office visit in less than 40 minutes sometimes takes great tact and skill.

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"Going to the doctor" may well be the biggest thing in the daily life of some quite elderly patient. It is his or her hour to shine and be important in a world which to them is diminishing; to get batteries charged for another go at family or institutional life; to get new ammunition with which to maintain courage and stature in a relentlessly shrinking environment.

As routine and seemingly futile as an office visit may appear to be at times, it calls for great empathy and authority in the true meaning of these words. In most instances it can and should be rewarding to patient, family and medical attendant. Any sign of boredom ("He's losing interest.") may well lead to the basic failure of an office or bedside visit. Remember, the waiting rooms of health cultists and racketeers are often full of people who have first tried going to reputable members of the medical profession.

To really win the trust and loyalty of patient and family the physician should show them and explain the laboratory report, read and interpret the x-ray findings for them and not hesitate to show actual x-ray films, especially if they show no abnormalities. Very often visual evidence helps greatly in enforcing awareness of what has just been told to the patient and the few extra minutes may be of great value in reassuring or managing an insecure or apprehensive elderly person. In so many instances to have a secretary or nurse tell a patient over the phone that "the reports are all right" is to render an actual disservice, with scant help to the patient and no boost to the doctor-patient relationship.

Keep medications few and simple. Often it is wise to submit a written (legible) memorandum of your orders. When one learns of drug bills of $100 or more per month, take stock and find out what is going on. Unfortunately often it will be found that much of this money is going for mega-vitamins or over-the-counter nostrums which are outrageously priced and relatively worthless. It takes tact and skill to wean some of these older patients from such overpriced and ill-advised concoctions. However, it is often possible to introduce standard approved preparations in much smaller and safer dosage. This is particularly true of many vitamin preparations.

Sedatives, tranquilizers and soporifics should be held to a strict minimum both numerically and as to dosage. Try as tactfully as possible to see that such medicaments are administered by some member of the family and not left in the possession of the patient; remember that these patients "sometimes forget." Actually laying out the day's medicines and establishing a checkoff system may be of value in preventing abuse or overdosage.

Today in many communities licensed physiotherapists or qualified physiatrists are available. Especially for patients with arthritic or other somatic aches and pains, skilled and periodic use of properly selected physical therapy modalities may be of considerable value. Appropriate traction apparatus with adequate instructions may be used at home with appreciable benefit. Often a well-chosen modality may actually lessen the need and use of large doses of analgesics. Without expecting cure many old people will be most grateful for the relief and the care. And results achieved by a skilled therapist in cases of impaired function sometimes are amazing.

Be aware of and do give advice concerning those mechanical and physical factors that can do much to improve an elderly patient's comfort, convenience and mobility. We are living today in an era of low (and I do mean down low) furniture, automobiles and other devices that for all ages are awkward or hazardous to get into, and always more difficult to get out of. Getting many of our 70- or 80-year-old citizens into and out of one of our modern "igloo" automobiles sometimes is a real problem. Put the television set at eye level or a bit higher, thereby lessening the aching or pain from prolonged flexion of the upper portion of the cervical spine—and it may help the oldster to stay awake a little longer. Put 4- or 6-inch blocks under each corner of modern, low beds; the hazard of falling out of bed is far less than the threat of a compression fracture of an osteoporotic vertebra in the desperate struggle of some octogenarian to rise from one of these infernal beds that has a mattress no more than four or five inches from the floor. I urge you to see that your waiting room has at least two chairs of standard height—and preferably they should be armchairs.

When closing an office visit with a bit of discussion and advice, have a spouse, a daughter or son, or some responsible adult present. How exasperating it is, after some little time and effort on your part, to learn that when asked later what the doctor had said your patient answered "Oh, nothing." Believe me, a family witness to your remarks may be most helpful.

Dietotherapy should not be too strict or too lenient. Your advice to "eat whatever you want"

is sometimes interpreted as lack of interest—or lack of skill. In general, patients are appreciative if you discuss with them their own particular relationship to salt, carbohydrates and cholesterol-containing foods. When indicated, suggestions for substitutes are also greatly appreciated. (There are some really quite tasty soy bean substitutes for cow's milk on the market. I know.) But in many instances it is important to emphasize to patients that an occasional serving or taste of a forbidden food is not going to result in disastrous consequences. When appropriate, my own advice has been "I can give you a diet in ten words—*fresh* meat, fish, fowl, dairy products, vegetables, fruit simply prepared."

Consultation should be sought when conditions change for the worse; or when uneasiness or dissatisfaction become apparent in a patient or members of the family. Whether warranted or not, set things straight by asking for consultation: "When you are right, you welcome consultation. When you are wrong, God knows you need it." A skilled consultant can often be of great help in making families appreciate your efforts. If a patient or family wishes a consultant who for a number of reasons may not be proper for the case, the attending physician always has the right to name two or more other doctors who he feels would serve the interests of patient and family better.

Some oldsters may react with hurt, anger or improper sense of rejection if the attending physician suggests consultation. This is especially true if psychiatric consultation is sought. Our present generation of old people are not oriented to the value of expert psychiatric opinion and advice, and are greatly affronted if the suggestion comes from the doctor in attendance ("He thinks I am crazy.") and the old person will carry to the grave the hurt and anger. There are often times when it is wise to have the suggestion for consultation of whatever kind come from a member of the family or a colleague. This might seem an evasion of responsibility and perhaps unfair to some colleague, but if the patient is returned to you with the blessing of the consultant you will still have a satisfied and loyal patient. If we are to have patients who are loyal, we must have patients and their families who have faith in their doctors.

One of the most difficult and unhappy situations a doctor has to meet is when it becomes necessary for an oldster to be sent to a so-called convalescent hospital or nursing home. More often than not, this is the last trip but one; old people know it, fear it and hate it. It may seem like condemning them, and may create a hurt and terror that will make their remaining days miserable. But for the sake of other members of the family, for the sake of *their* health as well as the health and well-being of the patient, these situations must be faced. Hard decisions have to be made and for the sake of the doctor-patient relationship, again, it is often better to have the initial suggestion come from the family or a colleague. The attending physician should endorse the decision but let it seem to come from elsewhere.

A final word about office visits: Do not tell a patient to come back when they feel like it. Rather, show your interest and responsibility by telling the patient to come back at a specific time, whether it is in a week or a year. If you tell them you will send a bill if they fail to show up, it serves to emphasize your role as their doctor although it is but a minor joke.

In summary one has to remember that if called on to render services to geriatric patients, the greatest good and the greatest service will be achieved if the attending physician can retain the trust and confidence of the senior citizen and his or her family. Do not hold out false hope and in general be candid with the patient as much as possible—but do not close the door on hope. Always tell it to the family straight, but in the case of a very old or enfeebled patient it is not necessary "to hit them over the head" with the blunt truth. Remember there are yet quite a number of oldsters running around in a spritely manner who "have been given up by seven doctors and saved by Charlatan's Golden Tonic."

To close I would like to tell of a true happening in my practice about 50 years ago, in the Prohibition era. A rough, tough, portly sheriff, in his 60's, from a northern California county came to me for a checkup. He told me that he had recently been to one of the doctors in his home town who after a brief examination said "Sheriff, how many cigars have you been smoking?" "And I sez to Doc 'Now listen, Doc, old age has taken away one of my pleasures, national Prohibition has taken away another, and no dam' doctor is going to take away my one remaining pleasure!' "

REFERENCES

1. Comfort A: Geriatrics—The missing discipline (Commentary). West J Med 128:257-259, Mar 1978
2. Watts MSM: Thoughts about geriatrics (Editorial). West J Med 128:235-236, Mar 1978